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TO: Each Supervisor

FROM: Jonathan E. Fielding, M.D., M.P.H. Jonathan E Fielding
Director and Health Officer

SUBJECT: **DEPARTMENT OF PUBLIC HEALTH - HEALTH FACILITIES INSPECTION DIVISION NURSING HOME INVESTIGATIONS**

At the March 4, 2014 meeting of the Board of Supervisors, your Board requested information about the Department of Public Health's (DPH) Health Facilities Inspection Division (HFID) and its handling of nursing home complaint investigations. Your Board directed DPH to report back on the issues raised by the March 3, 2014 *Daily News* article regarding nursing home complaint investigations, to address the mischaracterizations in the article, and to provide information on HFID's processes for following up on complaints.

The press coverage of this issue gives the erroneous impression that nursing home complaints are not carefully investigated by DPH. This is incorrect. HFID initiates an investigation of reported incidents occurring at skilled nursing facilities, whether based upon complaints or a facility's mandated self-reporting of incidents. A threat of imminent harm to any resident results in an investigation being initiated within 24 hours. Other incidents and complaints have investigations initiated within 10 days, almost always including an onsite inspection. Addressing a definitely or potentially harmful situation is HFID's highest priority.

Health Facility Inspections in Los Angeles County

The California Department of Public Health (CDPH) has contracted with DPH since the 1960s to provide licensing, certification, and inspection of health facilities in the County. DPH HFID provides these services for the approximate 2,500 health facilities in Los Angeles County which include: acute care hospitals, nursing homes, homes for the intellectually impaired, hospice programs, ambulatory surgical centers, dialysis clinics, home health agencies, community care clinics, and congregated living facilities (i.e., for the catastrophic and severely disabled, ventilator dependent, and terminally ill). The inspections evaluate compliance with federal and State regulatory requirements.

Each inspection or investigation team is comprised of an Environmental Health Specialist to conduct the safety code inspection and two to four nurses, depending on size of facility, to evaluate compliance in the services provided at the facility. These teams address complaint-based investigations and conduct regular surveys of facilities. Surveys occur at least every 15.9 months.

In FY 2008-09, the State required an increase in the frequency of surveys and evaluations of home health agencies, end-stage renal dialysis centers, and ambulatory surgical clinics, which further increased the workload burden for HFID staff.

Funding Constraints

The annual budget allocated by the State for DPH's HFID is approximately $26 million, which funds 151 positions. Current workload exceeds available staff resources available and DPH has annually requested a budget increase from the State since fiscal year (FY) 2008-09. Those requests have been denied. HFID has estimated that funding for the program to fulfill all State and federal requirements on a timely basis should be approximately $33.5 million.

The HFID program is allocated 178 positions by County ordinance, however DPH cannot hire on 27 of these positions due to the State's limited budget allocation to HFID.

Nursing Home Investigations

HFID investigates all reported incidents occurring at skilled nursing facilities: 1) investigations based upon complaints; and 2) investigations based upon the facility's mandated self-reporting of incidents ("Entity Reported Incidents" or "ERIs"). After a report of an incident is received by HFID (either through a complaint or an ERI), an investigation is initiated. If the complaint or ERI involves a threat of imminent harm to any resident it is investigated within 24 hours. If the threat of imminent harm is substantiated, immediate measures are taken to ensure the safety of the resident(s). Addressing a definitely or potentially harmful situation is HFID's highest priority. Other incidents and complaints have investigations initiated within 10 days.

If deficiencies are uncovered as a result of HFID's investigation, the results are entered into a federal/State database. A written document is produced and given to the facility, outlining the deficiencies and requiring the facility to develop a corrective action plan. Once received, corrective action plans are also entered into the federal/State database. The documented deficiencies and corrective action plans are accessible to the public through the State/federal database, which is managed by the Federal government. There is a time-lag between when HFID staff enter the data and when it is available through the public portal of the State/federal database.

Investigations can sometimes take several months and can involve working with outside agencies to obtain necessary information that may delay finalization of the report, e.g., the County Coroner to obtain cause of death reports and law enforcement. The final step in the process after the investigation is complete and deficiencies are addressed is to write a final report. The completion date of the report is entered into the State/federal database and a hard copy of the report is kept in the HFID files for audit purposes. It takes an average of 16 hours to write a final report with all of the State and federal required forms.

For calendar years 2000 through 2013, HFID received a total of 29,837 complaints and ERIs. Of the 29,837 complaints, HFID formally closed out 27,632 cases. The remaining 2,205 cases have all been investigated but the only remaining work to be completed is the writing or completion of the final report. The following table shows that for calendar year 2013, of the 3,381 cases received by HFID, 1,616 are a combination of investigations awaiting final pieces of information to complete and completed investigations awaiting final reports. Forty percent of the 806 complaints and 65 percent of the 810 ERIs are pending a final report but have been fully investigated.

Health Facilities Inspection Division Complaints and Entity Reported Incidents, Calendar Year 2013

	Total Received	Report Pending	Closed	No Action Necessary*
Complaint	1,362	806	556	40
Entity Reported Incidents (ERIs)	2,019	810	1,209	393
All	3,381	1,616	1,765	433

* "No action necessary" indicates that the complaint allegations or self-reported incidents at face value do not constitute a State or federal regulatory violation, and no investigation is required. ERIs are frequently received from facilities that out of caution over-report incidents that do not constitute regulatory violations or raise concerns that would require an investigation.

In 2011, the State provided guidelines to district offices to reduce a backlog in closing out lower-priority ERI investigations. These guidelines permitted closing out older ERIs where a facility was determined to be in substantial compliance during their last survey. DPH followed these guidelines. Lower-priority investigations are ones in which alleged abuse, neglect, or pending legal action is not involved. However, no such guidelines were given by the State for complaint-based investigations. HFID followed the guidelines and closed ERI cases accordingly.

To prioritize HFID staff resources effectively while trying to comply with the State mandate to close more cases, starting in late August 2013, HFID applied a more stringent set of requirements than the State's guidelines for ERI investigations to the lower-priority complaint investigations. HFID closed out older lower-priority complaint investigations if two full survey reviews conducted after the initial complaint was received found the complaint to be unsubstantiated. While reasonable this procedure was not approved either by the State or DPH leadership. We suspended the revised complaint closure process as of February 28, 2014 at State request.

Mischaracterization of HFID's Investigation Follow-Up

The March 3, 2014 *Daily News* article published in several southland newspapers gives the erroneous impression that complaints were not investigated. This is incorrect. DPH has undertaken investigations of all complaints. However, part of the backlog includes investigations that were initiated, may or may not have substantiated the complaint, and require final steps in the process to document the deficiencies, a plan of corrective action and development of a final report.

Next Steps

HFID staff will continue to work to ensure that all complaints are appropriately investigated and handled. However, it is not realistic to expect a rapid reduction in the backlog without additional resources. Staff will cooperate with both State and County auditors to review the current program operations and response to complaints. While the relationship between the HFID District Offices and the various Ombudsmen serving Los Angeles County is generally good, HFID staff will be asked to look at ways to strengthen these relationships.

DPH is committed to working with the State to secure sufficient resources and to streamline current processes to fulfill all State and federal requirements. DPH will also work to improve internal procedures so that future communication on issues such as these will result in more timely notification to your Board.

If you have any questions or need additional information, please let me know.

JEF:EP: jb

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors